Prescription Drug Record

Mail to: **Aetna U.S. Healthcare**
P.O. Box 14586
Lexington, KY 40512-4586
1-800-367-6276

Employer Information

Name: **Department of Defense Nonappropriated Fund Health Benefit Programs**

Policy/Group Number: **721027**

Employee Information

Social Security Number: – –

Name

Birthdate (MM/DD/YYYY)

☐ Active ☐ Retired
Date of Retirement

Address (include zip code) ☐ Address is new

Daytime Telephone Number ( )

Patient Information

Social Security Number: – –

Name

Birthdate (MM/DD/YYYY)

Relationship to Employee
☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from employee)

Sex
☐ Male ☐ Female

Full Time Student
☐ No ☐ Yes

Expected Graduation Date

School Name

Marital Status
☐ Married ☐ Single

Is patient employed?
☐ No ☐ Yes
Date of Retirement

Name/Address of Employer

Other Coverage Information

Are any family members expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator

Member's Social Security Number: – –

Member's Name

Member's Birthdate (MM/DD/YYYY)

Claim Information

Is claim related to an accident?
☐ No ☐ Yes If yes, date _____ time _____ ☐ am ☐ pm

Is claim related to employment?
☐ No ☐ Yes

Description of Accident

Prescription Drug Record

If additional space is needed to provide the following information, please use the back of this form.

Date Purchased	Prescription Number	Name of Drug/Quantity Mark "G" if Generic	Dose Per Day/Strength (e.g.), 3 per day, 4 per day)	Nature of Illness or Injury	Prescribing Physician	Store Name, Address & Number	Amount Charged

Release

To all providers of health care:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting health professionals and utilization review organizations with whom Aetna has contracted, information concerning health care advice, treatment or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

Employee Certification

I hereby certify that the above drugs and medicines were necessary for treatment of the illness/injury reported and were purchased by me or my eligible dependent(s) named above. I understand that the bills, prescriptions and other data pertaining to the above items are to be retained by me for 12 months from this date and are to be made available to the Aetna, if requested.

Employee's Signature _____ Date _____

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.